



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

ETMC FIRST PHYSICIANS

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-18-0262-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

SEPTEMBER 29, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Claim was originally sent to patient's health insurance. Patient received 4 statements before notifying us on August 3, 2017 this was a Worker's Compensation Claim."

**Amount in Dispute:** \$1,926.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual has no record of receiving copies of the original bills the requestor submitted to the incorrect carrier nor has it provided any with its DWC60 packet."

**Response Submitted by:** Texas Mutual Insurance Co.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2017	CPT Code 99223	\$377.00	\$319.84
April 15, 2017	CPT Code 99221	\$198.00	\$159.83
April 16, 2017 April 18, 2017	CPT Code 99233	\$207.00/ea	\$329.56
April 17, 2017 April 19, 2017 April 20, 2017 April 21, 2017 April 22, 2017	CPT Code 99232	\$141.00/ea	\$570.15
April 23, 2017	CPT Code 99239	\$232.00	\$169.32
TOTAL		\$1,926.00	\$1,548.70

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
  - CAC-29-The time limit for filing has expired.
  - 731-Per 133.20(B) provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service.

### **Issues**

1. Did the requestor support position that the disputed bills were submitted timely?
2. Did the requestor support position that the disputed bills meets exception for timely filing?
3. What is the appropriate reimbursement for the disputed services?

### **Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "CAC-29-The time limit for filing has expired."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation finds fax confirmation reports that support the disputed bills were not submitted timely to the respondent.

2. The requestor contends that reimbursement is due because "Claim was originally sent to patient's health insurance. Patient received 4 statements before notifying us on August 3, 2017 this was a Worker's Compensation Claim."

Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

The requestor submitted explanation of benefits from Blue Cross and Blue Shield that are dated within the 95 day timeframe for the disputed services. The division finds the requestor supported position that the disputed services qualify for the exception found in Texas Labor Code §408.0272(b)(1). As a result, reimbursement is recommended.

3. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 21-Inpatient Hospital.

The 2017 DWC conversion factor for this service is 57.5.

The Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75701, which is located in Tyler, Texas; therefore, the Medicare participating amount is based on locality “Rest of Texas”.

Using the above formula, the division finds the following:

Code	No. Of Units	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
99223	1	\$199.63	\$319.84	\$0.00	\$319.84
99221	1	\$99.76	\$159.83	\$0.00	\$159.83
99233	2	\$102.85	\$164.78 X 2 = \$329.56	\$0.00	\$329.56
99232	5	\$71.17	\$114.03 X 5 = \$570.15	\$0.00	\$570.15
99239	1	\$105.68	\$169.32	\$0.00	\$169.32
TOTAL					\$1,548.70

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$1,548.70.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,548.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### Authorized Signature

_____	_____	11/1/2017
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**